DOCUMENT RESUME

ED 275 457 PS 016 174

AUTHOR Cooper, Carolyn
TITLE Parent Involvement in the Diagnostic Assessment of Children.
PUB DATE Oct 86
NOTE 16p.; Paper presented at the Annual Conference of the National Black Child Development Institute (16th, Miami, FL, October 8-10, 1986).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Children; *Disabilities; Early Childhood Education; *Educational Diagnosis; *Handicap Identification; *Parent Participation; Program Descriptions; Screening Tests
IDENTIFIERS *Childrens Diagnostic Center VA

ABSTRACT

This paper describes the Children's Diagnostic Center, an innovative model project at Hampton University in Virginia. The center was established to provide high quality, multi-disciplinary evaluations of children thought to have conditions likely to interfere with normal development; to describe resources and services available to parents to assist them in making informed decisions; and to enhance the development of college students at the pre-professional level by training them to actively participate in evaluation activities. Contents describe the staff; parent involvement techniques; the communication of assessment data to parents; an agenda for discussing evaluation results; and an outline of steps for providing an overview of evaluation results. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED275457

Hampton University
Hampton, Virginia

Children's Diagnostic Center

PARENT INVOLVEMENT

IN THE DIAGNOSTIC ASSESSMENT OF CHILDREN

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Carolyn I. Cooper

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

PS 016174

Presented at National Black Child Development Institute Conference

Carolyn Cooper, Ed.D. Director
Children's Diagnostic Center
October, 1986

INTRODUCTION

Educationally handicapping conditions, if undetected, can have a negative effect on the handicapped child, the family, and the community for the lifetime of the individual. Early detection and diagnosis can permit intervention strategies to benefit the handicapped youngster. The Children's Diagnostic Center (CDC), an innovative model project, was established at Hampton University in 1982 through support from the United States Department of Education, Office of Special Education and Rehabilitative Services and the Department of Elementary and Special Education in the Hampton University School of Education. It has three major purposes. First, it seeks to provide quality, multi-disciplinary evaluations of youngsters who are suspected of having handicapping conditions that may interfere with their physical, educational, or psychological development. Second, it explains available resources and services to assist parents in making informed decisions for their child. Third, it strives to enhance the development of college students at the pre-professional level by training them to be active participants of a multidisciplinary evaluation team.

THE STAFF

The staff of the Children's Diagnostic Center is composed of the clinical and project director, the project co-director, staff psychologist, and speech-language pathologist. Undergraduate and graduate students from the disciplines of psychology, communication disorders, special education and regular education also serve as staff members. Consultants to the project on a regular schedule include a social worker, a registered occupational therapist, and a pediatrician. The students who spend one full semester in the clinic are known as clinical interns. They are assigned to one of two equivalent teams. Each of the teams is responsible for the administration and interpretation of selected testing instruments on an alternating weekly schedule in the following areas: educational, social-behavioral, perceptual, speech-language, psychological, and screenings in vision, and hearing.

PARENT INVOLVEMENT TECHNIQUES

Traditional methods for involving parents in the assessment process of their children have typically centered on one-way communication (Simpson, 1980). Parents have answered questions asked by professionals. At some later time, the professional has presented to the parent(s) a comprehensive picture of how their child behaves and performs academically. There is usually little opportunity for two-way communication and sharing of information.

The CDC strives to consistently involve parents through a sharing process. It begins with the completion of two forms prior to the scheduled home visit. The Parent Rating Scale of the Behavior Rating Profile (Brown and Hammill, 1983) consists of 30 descriptions of home behaviors (for example, "My child is shy and clings to me"). Each description is rated as "very much like my child," "like my child," or "not at all like my child." This scale can be completed by the child's mother or father or both parents may rate the child independently.

The Health Inventory Form (McKnight, 1983) is composed of questions related to the following areas: the mother's pregnancy and birth of the child, motor milestones, accidents and illnesses, and school and discipline problems. In most instances the parents may respond by circling yes or no. The completion of these two forms before the home visit allows the team leader and the consulting social worker to review the information and seek clarification of ambiguous or unclear information during the home visit.

At the discretion of the parents, all significant "others" who are involved in the care and welfare of the child are invited to participate in the home visit. Priority in scheduling the visit is given to the demands of the family, rather than the time needs of the clinic staff. The purpose of the visit is to obtain sociocultral data that might affect the child's, educational performance. Variables for consideration include size of the family, living and studying conditions, educational values, family status and crises, as well as the child's relations with family

members. Information about favorite recreational activities and types of friendships may also contribute to an understanding of the child and his family. A portion of the time during the home visit is set aside to fully explain the clinic assessment procedures. In addition, family members are given time to contribute any information they deem necessary to provide a comprehensive picture of the child.

At the conclusion of the home visit, the parent(s) are required to sign a Permission Form granting consent for the CDC to conduct the evaluation. An Exchange of Information Form (McKnight, 1983) is also completed at this time. This form is used to request or send information between the CDC and any other agency.

The multidisciplinary team assumes responsibility for analyzing the evaluation information. This is accomplished at two levels. The first is the individual level where scoring and interpreting of each evaluation instrument is accomplished. The

second level is a group process. All information related to the multidisciplinary assessment of the child is presented at the team staffing. This data is analyzed to obtain a composite of the child's performance as well as his strengths and weaknesses. Recommendations to enhance the optimal educational development of the child are also developed.

COMMUNICATION OF ASSESSMENT DATA TO PARENTS

The written clinical evaluation data is shared by the team leader, the director, and the psychologist with the parent(s) and significant "others" of their choice at the Diagnostic Summary Conference. This conference provides a dialog for a discussion of the evaluation results and creates a climate for the most complete and comprehensive picture of the child's instructional needs to emerge. According to Turnbull and Turnbull (1986), the advantages of presenting oral and written findings to families for face to face discussion and sharing include the following.

1. Evaluation data is often highly technical. Written explanations alone may not be completely informative.

2. Family members can share information on the child's special needs and confirm whether or not the performance described by the clinic staff is typical.

3. Providing family members with a copy of the Diagnostic Summary Report permits them to relax during the conference since they will not have to take notes and may refer to the Diagnostic Summary as needed during the conference. It also provides written clarification for families to refer immediately after the conference.

An Agenda for Discussing Evaluation Results with Parents (Rockowitz and Davidson, 1979) is employed in the CDC. It provides a systematic structure for conducting the summary conference. Note that this agenda is intended to support parents by scheduling time for them to actively participate and respond after the overview as well as after each recommendation (★).

AGENDA FOR DISCUSSING EVALUATION RESULTS

Initial Proceedings

A. Introductions

B. Review of evaluation procedures

C. Parents' perceptions of child's functioning

D. Restatement of referral concerns

Presentation of findings

A. Overview of evaluation results

B. Reaction by parents (and child, if present)*

C. Detailed findings

1. Strengths

    a. Identification of strengths

    b. Parent reactions*

    c. Implications for instructional programming

2. Weaknesses
    a. Identification of weaknesses
    b. Parent reactions*
    c. Implication for instructional programming

3. Classfication of student according to an exceptionality

Recommendations (only after time has been allowed for reactions)

A. Restatement of concerns
B. Recommendations-one at a time
C. Reactions after each recommendation*
D. Determination of whether the child should receive special education
E. Strategies for sharing evaluation results with the child

Summary

A. Repetition of findings, in varied wording if possible
B. Restatment by parents
C. Planning for next step.

In attempting to provide jargon-free, clear communications to parents, the CDC also employs an Outline of Steps for Providing an Overview of Evaluation Results (Hirsch, 1981). In addition to the outline, an example of each step is included. The application of these steps makes the information more easily understood by parents.

OUTLINE OF STEPS FOR PROVIDING AN OVERVIEW OF EVALUATION RESULTS

Introduce the skill: Label skill or concept; give skill definition; give skill examples.	We tested Vicki's self-help skills (skill label). Those are things she needs to do every day to take care of herself (skill definition) like washing her face or going to the bathroom (behavior examples).

State child's current level of functioning on the skill; state student's function level; state how this compares to chronological age peers.	Vicki is about the two year level on these skills (function level), about a year behind average children her own age (amount of delay)
Give examples: give examples of skills child can and cannot perform.	Vicki can do such things as eat with a spoon and fork, tell what is and is not food, and walk up the stairs by herself (skills child can do). But she has not learned to go to the toilet, get a drink by herself, or put on her own coat, things most three-year-olds can do (skills child has not learned to do).

Address the importance if any discrepancy noted between age and achievement: discuss in terms of how discrepancy may affect child's development at present and in future.	If Vicki does not learn to take better care of herself, she will have a difficult time adjusting to school since she will be so dependent on the teacher to help her with things other children can do on their own (possible future effect of discrepancy).

At the conclusion of the Diagnostic Summary, the parents are invited to return to CDC at a later time if they need further clarification about the evaluation. Parents are given a copy of the Handbook for Parents of Handicapped Children: Rights and Responsibilities (Virginia Department of Education, 1983). This pamphlet explains the following items:

The Special Education Process

Complaint Procedure for Programs for Handicapped Children

The Impartial Due Process Hearing

Rights and Responsibilites-Parents and School Division

Glossary of Special Education Terms

The chance for students to receive the best possible education are enhanced when parents are well informed. School officials often report that there is a positive difference in parent attitudes when they understand their rights and responsibilities and are active participants in the education of their child.

References

Brown, L.L. and Hammill, D.D. Behavior Rating Profile - Parent Rating Scale. Austin, TX: PRO-ED, 1978.

Hirsch, G.P. Training Development Disability Specialists in Parent Conference Skills. Doctoral Dissertation. Kansas: University of Kansas, 1981.

McKnight, T. Children's Diagnostic Center - Health Inventory Form. Hampton, VA: 1983.

McKnight, T. Children's Diagnostic Center - Exchange of Information Form. Hampton, VA: 1983.

Rockwitz, R.J. and Davidson, P.W. "Discussing Diagnostic Findings with Parents," Journal of Learning Disabilities 12 (1979) 13.

Simpson, R. Conferencing Parents of Exceptional Children. Rockville, MD: Aspen Systems, Corporation, 1982.

Turnbull, A.P. and Turnbull, H.R. Families, Professionals, and Exceptionality: A Special Partnership. Columbus, OH: Merrill Publishing Co. 1986.

Virginia Department of Education. Handbook for Parents of Handicapped Children. Richmond, VA: 1983.